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OFFICIAL JOURNAL OF THE SOUTHWESTERN MEDICAL ASSOCIATION AND EL PASO COUNTY MEDICAL SOCIETY

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EL PASO, TEXAS

De Rebus Medicis Et Politicis

BY ROBERT B. HOMAN, JR., M. D., EL PASO, TEXAS
MEMBER OF THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION

NOW KNOWN AS COMPULSORY "RE-INSURANCE"

On March 14, 1953, President Eisenhower addressed the House of Delegates of the A. M. A. He said, "I don't like the word "compulsory" and I am against the word "socialized." Everything about such words seems to me to be a step toward the thing that we are spending so many billions to prevent, that is, the overwhelming of this country by any force, power, or idea that leads us to forsake our traditional system of free enterprise." He promised that the present administration would not be the big "Pooh-Bah" in the field of medical care.

What a difference a year makes! Perhaps the President continues to be allergic to compulsion and to socialism, but his pronouncements regarding the welfare of the people of this country have a strange resemblance to the product of those hated words. "Ike" seems to have taken the bait with the hook, line, and sinker. The bait, of course, is re-election.

Apparently the Republicans have decided that social welfare programs — extended from cradle to grave — are the vote-getting attractions necessary to a prolonged sojourn at the Washington wheel. After all, with the inevitable slide in the inflated "prosperity" of the past few years and a not too healthy condition in foreign policy, the party needs something besides "Ike's" personality to hang onto. Such must be the reasoning of the party dedicated to free enterprise. Of course, that reasoning has been somewhat biased by advice from the old and new crop of social planners. (We seem to have taken them aboard for all time).

COERCION DEFINED

Webster's New Collegiate Dictionary defines *compulsory* —1. obligatory. 2. coercive. Coerce is defined, 1. to repress; curb. 2. to compel to any action. 3. to enforce; as, to coerce obedience. The administration has introduced a bill which would require that 10 million self-employed Americans would be *compelled* or *forced* to join the Social Security—Old Age Pension tax robbery. These Americans have not demanded such "consideration" from our government. In fact, they are opposed to the entire forced taxation from which the majority will never receive return, or benefits. Is this not compulsion?

Now the Republicans have come forward with a "dynamic" program for the health problems of Americans, which includes subsidization of medical research, the promotion of research; the construction of research centers, medical centers, nursing homes for the chronic invalids and the aged, health centers, and hospitals. Whatever the Federal government subsidizes, it has the right to control. The Supreme Court has so held.

Another proposal designed to expand medical care under Federal subsidy is that which would "re-insure" all "private and non-profit" voluntary health insurance companies through the creation of another federal bureau — a government re-insurance corporation. This approach would "encourage private and non-profit health insurance organizations to offer broader protection to more families", through the use of the taxpayer's dollar. It would also take away the freedom of these voluntary companies and place them under direct control of a Washington bureau, with the usual rules, regulations, and social jargon not yet spelled out in detail.

FURTHER COMPULSION

Furthermore, the large and small insurance companies operating for profit under free enterprise would be *compelled* to get out of the health field for they could not compete against a government subsidiary. The non-profit organizations have a greater freedom of choice. They would be compelled *either* to dissolve *or* become the agents of the government system of health care thus created.

In his message to Congress on these health proposals, the President said, "Freedom, consent, and individual responsibility are fundamental to our system." He also said, "I am opposed to socialized medicine!"

Oscar Ewing and Harry S. Truman also said that they were *opposed* to socialized medicine, but they were *for* compulsory health insurance. "A rose by any other name would smell as sweet."

NEW EL PASO MEDICAL CENTER HOUSES 51 DOCTORS AND DENTISTS

Panoramic view of El Paso's handsome new medical center.

All units of El Paso's handsome new $1.2 million Medical Center have been completed and occupied with the exception of the Commercial Section, which is scheduled for completion by the end of March.

Of distinctive Southwestern design, the Center covers approximately 19 acres on the extreme Southern end of the Rocky Mountains above the Rio Grande. It offers complete clinical and X-ray service and laboratory facilities in a location centralized in respect to El Paso's hospitals and population. Each doctor has his individual suite tailored to suit his personal needs and practice.

The project is owned and operated by the Medical Center Corporation, composed of the 51 doctors and dentists whose offices occupy the buildings. The doctors, as individuals, rent their office and laboratory space from the corporation.

The Center, constructed by Robert E. McKee, General Contractor, Inc., is composed of nine separate medical buildings and the Commercial Section building. The Commercial Section building is now being finished, and the prescription pharmacy in the section will be opened by March 1. Other units of the Section, designed by Davis and Foster, leading Southwest architects and engineers, will be opened for business as they are completed.

The Center, located at 1501 Arizona St., has a paved parking area for 600 cars and an additional area available for four or five more buildings and parking for another 300 cars for future expansion.

The pharmacy, to be operated by W. U. Paul, former administrator of Southwestern General Hospital, and C. Harris, formerly with Gunning-Casteel Drug Stores, will be one of the most modern and completely stocked prescription pharmacies in the Southwest. It will be designed to serve both the doctors in the Medical Center and the general public, and delivery service will be offered. Workmen are rushing construction of the pharmacy end of the commercial building so that it may be put into service as soon as possible.

The restaurant will be operated by Gerald Wolfe, well-known motel dining room operator. Modern new equipment will be installed by Harry L. Hussmann, Jr., Inc.

The commercial section will also house the office of the Medical Center superintendent, maintenance shops, storage rooms; and a retail orthopedic and brace shop will be installed by Mr. and Mrs. J. H. Wilmot of Albuquerque.

Transportation to and from the center is provided by El Paso City Lines, which operates a bus line from downtown El Paso to the center, from the Center to East El Paso, and return over the same route. The busses stop at each of the doctors buildings in the center.

Officers of the Medical Center corporation are: Dr. Leigh E. Wilcox, president; Dr. Joe Floyd, treasurer; Dr. S. Perry Rogers, secretary; Dr. M. P. Spearman, first vice-president; Dr. Leslie M. Smith, second vice-president; Dr. Robert Boverie, third vice-president; Dr. Clement C. Boehler, assistant secretary, Dr. George Turner and Dr. O. J. Shaffer, directors. Paul Deisler, El Paso management consultant, is executive secretary.

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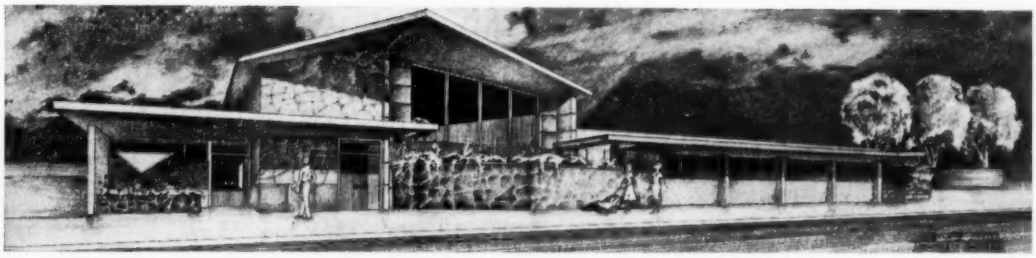

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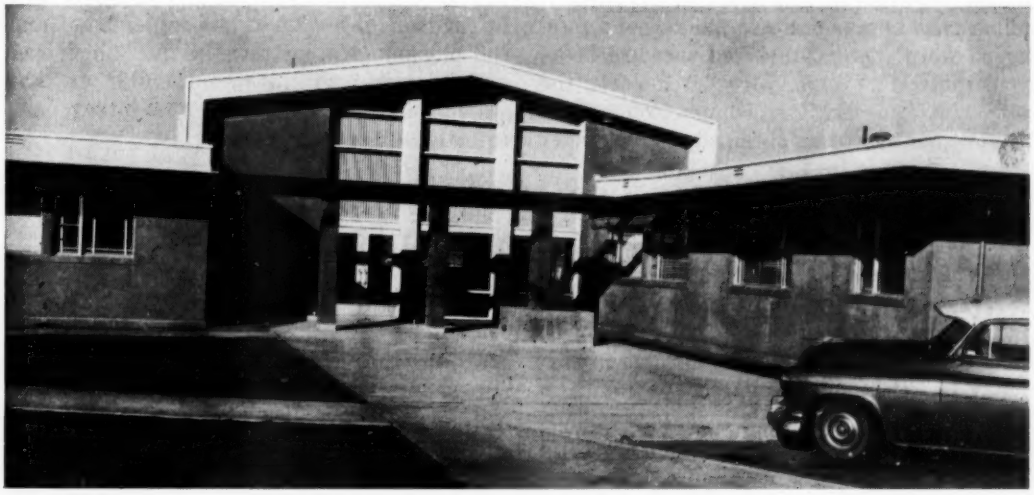

One of numerous physicians' office buildings which with the Commercial Section compose El Paso's new Medical Center. Offices are tailored to the specifications of physician or dentist. Parking space is abundant.

Post-Graduate Medical School Is Scheduled for El Paso

Plans for the first teaching session, to be held this spring, were made February 13 and 14 in El Paso by officials of the recently-established El Paso branch of the University of Texas Post-graduate School of Medicine.

At the meeting were Dr. Grant Taylor of Houston, newly appointed Dean of the post-graduate school, Dr. Mavis P. Kelsey, who has served as Acting Dean, Dr. Ralph H. Homan, chairman of the El Paso County Medical Society's educational committee, and members of that committee.

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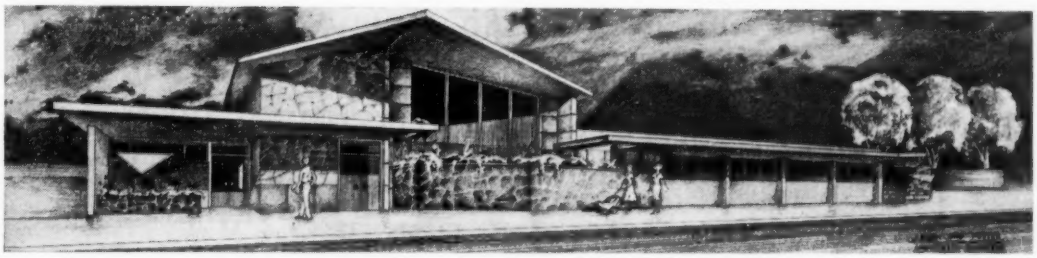

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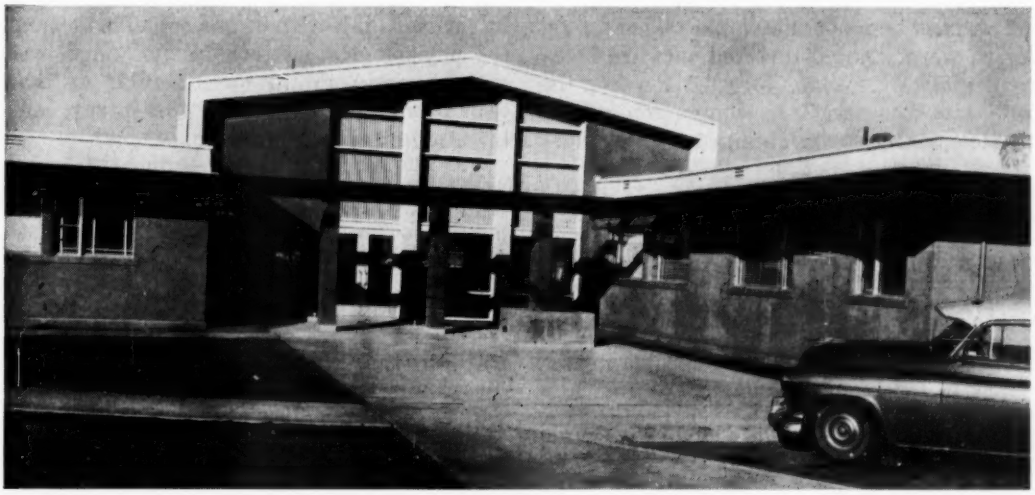

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PROCEEDINGS OF THE NEW ENGLAND CARDIOVASCULAR SOCIETY* INVITED PAPERS FROM NEW ENGLAND

STUDIES OF STRESS: INTERRELATIONSHIP OF EMOTIONAL RESPONSES AND CARDIOBALLISTOGRAPHIC TRACINGS

By Daniel H. Funkenstein, M. D., Stanley H. King, M. A., and Margaret Drolette, B. A.

Seventy healthy randomly selected college students' reactions were studied during a laboratory stress-inducing situation. Their psychological emotional responses were obtained by interview, and concomitantly the following physiological measures were obtained: by cuff and auscultation, the systolic and diastolic blood pressure, and by means of a cardioballistographic tracing, the pulse, the height of the IJ wave and the pulse multiplied by the height of the IJ wave.

The most common emotional responses reported were: "anger directed outward away from the self", "anger directed towards the self" and "anxiety." A comparison of the physiological patterns obtained in the "anger directed outward" group with those in the "anger directed inward" group showed statistically different patterns. The "anger out" group's physiological pattern also differed statistically from the "anxiety" group. The physiological patterns in the "anger in" group and the "anxiety" group were similar, although the "anxiety" group showed a more intense physiological response. The pattern obtained in the "anger out" group was similar to that which can be obtained by the intravenous injection of nor-epinephrine, and the physiological pattern in the "anger in" and "anxiety" groups was similar to that which can be obtained by the intravenous injection of epinephrine.

ACUTE PERICARDITIS COMPLICATING INFECTIOUS MONONUCLEOSIS

By Henry Miller, M. D., Joseph F. Urrichio, M. D., and Roswell W. Phillips, M. D.

A review of the subject of cardiac involvement in infectious mononucleosis indicates that the cardiac complications are usually subclinical, benign, and manifested by transient, nonspecific electrocardiographic abnormalities. There is apparently no correlation between the electorcardiographic deviations, clinical findings or severity of the disease. In recent years, autopsy confirmation of the existence of myocarditis in infectious mononucleosis has become available. That pericarditis can occur in this disease was first suggested by Evans and Graybiel in 1946. A single case was reported by DeFazio and Marsico in 1948. The present report was based on three patients each of whom develoed clinical, hematological and serological evidence of infectious mononucleosis. A pericardial friction rub with typical electrocardiographic changes appeared in each case with roentgen evidence of cardiac enlargement in two. In each recovery was complete. The possibility that we were dealing with two independent diseases, namely; acute idiopathic pericarditis and infectious mononucleosis or rheumatic pericarditis complicating infectious mononucleosis was considered and discussed. In considering the pathogenesis of acute pericarditis in infectious mononucleosis, several possibilities were considered. 1. The proximity of the hilar lymph nodes with extension of the infection into the pericardial sac. 2. A virus infection of the pericardium. 3. A hypersensitive response of the pericardium as a shock organ to an offending allergen in a sensitive individual.

*These condensed reports published by permission of the New England Cardiovascular Society.

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INVITED PAPERS FROM NEW ENGLAND

THE DURATION OF THE Q-U INTERVAL OF THE ELECTROCARDIOGRAM AND ITS COMPONENTS IN HYPOPOTASSEMIA WITH AND WITHOUT HYPOCALCEMIA

By E. Lepeschkin, M. D., and B. Surawicz, M. D., Division of Experimental Medicine, University of Vermont College of Medicine, Burlington, Vermont

In many cases of hypopotassemia an accurate measurement of the Q-T duration is very difficult because of partial or complete fusion of the T and U waves. The authors thought it possible that in such cases the components of the Q-T duration, such as the interval from Q to the origin (oT) or apex (aT) of the T wave, which often can be measured with greater accuracy, could be used instead of the Q-T duration. They also believed that the time of appearance of the apices of the T and U waves (aT and aU) as well as their relations to the second heart sound would enable a better differentiation between these two waves. For this purpose the exact relations of all the component parts of the entire interval to the end of the U wave (Q-U interval) to the heart rate, and other variables were studied in 100 normal cases. The point oT was defined as the point furthest away from a straight line connecting the RS-T junction with the apex of T. All points were measured in leads showing the highest T waves.

It was found that the normal Q-oT and Q-aT intervals showed exactly the same dependence on the heart rate as the Q-T interval, and that when they were expressed as a percentage of the Q-T expected for the heart rate, this percentage remained constant for all heart rates. The normal Q-aU interval was found to equal the Q-T interval expected for the heart rate, plus 0.10 sec. The beginning of the second heart sound in normals always occurred at least 0.06 and on the average 0.085 sec. after the apex of the T wave; in certain pathological cases, the distance may be zero or even slightly negative. The apex of U always occurred at least 0.04 sec. and on the average 0.09 sec. after the beginning of the second heart sound. If, therefore, the apex of a questionable wave occurs before the beginning of the second sound, this apex is definitely formed by the T wave. If this apex occurs after the beginning of the second sound, it is most probably but not certainly formed by the U wave. This relation of the second heart sound can be obtained with any electrocardiograph by registering the ECG through a magnetic radio headphone whose membrane is in direct contact with the aortic region.

In 20 cases of hypopotassemia without concomitant hypocalcemia or acidosis, in which the U and T waves could be adequately differentiated (personal cases as well as those published by others), the Q-oT interval averaged 53 per cent but did not exceed 65 per cent of the expected Q-T interval, while the Q-aT interval averaged 78 per cent and did not exceed 92 per cent of this interval. These values, as well as those of the Q-T, Q-aU, and Q-U intervals, were practically identical with those found in normals at the same heart rates. In 20 cases of hypocalcemia, similarly selected, the Q-oT interval averaged 82 per cent and always exceeded 63 per cent of expected Q-T, Q-aT averaged 108 per cent and exceeded 84 per cent, Q-T averaged 132 per cent, while Q-aU and Q-U were practically identical with normal values. In 5 cases of hypopotassemia accompanied by hypocalcemia, Q-oT averaged 75 per cent and always exceeded 65 per cent, Q-aT averaged 100 per cent and exceeded 89 per cent, Q-T averaged 123 per cent and exceeded 112 per cent of expected Q-T, while Q-aU and Q-U had normal values for the heart rate. In two cases (one of these personal) of hypopotassemia with hypocalcemia, administration of calcium did not change the amplitude of the waves or the duration of the U wave, but caused a marked shortening of the Q-aT, and especially of the Q-oT interval. On the other hand, administration of potassium in another case from the literature, normalized the configuration of the waves without changing the duration of the intervals.

In normals as well as in cases of hypopotassemia, hypocalcemia accordingly caused

(Continued on Page 119)

MISCELLANEOUS APHORISMS AND MEMORABILIA

By Andrew M. Babey, M. D., Las Cruces, N. M.

1. "The bacteria which may be found in the blood without any localizing signs of infection are typhoid-paratyphoid bacilli, Bacillus melitensis, meningococci, and gonococci; less often the common pyogenic organisms, such as Streptococcus hemolyticus, Staphylococcus aureus, or Bacillus coli are found. The presence of bacteremia due to the common pyogenic organisms, without local signs of infection, should always suggest an intervascular focus, such as an infective thrombophlebitis or endocarditis."—Chester S. Keefer, N. Y. State J. of Med., May 1, 1941 *p* 976.

2. "Hemolytic streptococcic bacteremia without obvious local signs of infection should suggest: (1) thrombophlebitis of the pelvic or the tonsillar veins or the veins of the skull, or (2) endocarditis." Chester S. Keefer, *loc. cit.*

3. "Staphlycoccus a u r e u s bacteremia without localizing signs of infection usually indicates an infective endocarditis or an osteomyelitis that has failed to produce focal symptoms. Other foci of infection which may be responsible for the bacteremia are located in the kidney, prostate, or muscles." —Chester S. Keefer, *loc. cit.*

4. "Pneumococcus bacteremia w i t h o u t pneumonia is seen in: (1) osteomyelitis, especially in children; (2) paranasal sinus disease; (3) pneumonococcic infection of the peritoneum or biliary passages, especially in patients with a latent cirrhosis of the liver or lipoid nephrosis; (4) pneumococcic endorarditis."—Chester S. Keefer, *loc. cit.*

5. "Colon bacillus bacteremia without local signs of infection is rare. However, it may be seen in multiple abscesses of the liver following abdominal operations (gastric resection or intestinal resection) and in rare cases of biliary tract disease, endocarditis, or cirrhosis of the liver."—Chester S. Keefer, *loc. cit.*

6. "Streptococcus viridans b a c t e r e m i a occurs most often as a sign of bacterial endocarditis. Aside from this disease, it may be encountered in rare cases of cholangitis (cholangitis lenta), in subacute endaortitis, and in an infected arteriovenous aneurysm. As a transitory phenomenon, Str. viridans bacteremia may be seen following tonsillitis, tonsillectomy or the extraction of teeth. It may also be discovered during the course of many chronic diseases such as rheumatic fever, chronic arthritis, and lupus erythematosis. The interpretation of Str. viridans bacteremia, therefore must be made on the basis of the clinical picture and the local symptoms and signs."—Chester S. Keefer, *loc. cit.*

7. "Hemolytic Streptococcic Bacteremia. —This is the most frequent type of bacteremia encountered in medical practice. The organisms enter the blood most often from: (1) the middle ear and mastoid process, including the lateral sinuses of the skull; (2) the uterus; (3) the skin and subcutaneous tissues. Metastases are present in only 40 percent of the cases, and they occur most often in the joints, subcutaneous tissues, and endocardium. Other less common sites for metastases are the bones and the lung."—Chester S. Keefer, *loc. cit.*

8. "Staphylococcus Aureus Bacteremia — This type of bacteremia is second in order of frequency when organisms are considered. The common portals of entry for the Staph. aureus are: (1) the skin, (2) the respiratory tract, (3) the bones, and (4) the genitourinary tract, including the uterus. Staph. aureus bacteremia is seen most often during the second decade, when lesions of the skin, the respiratory tract, and bones are common portals of entry. Metastatic lesions are frequent and occur in about 82 to 85 percent of all cases. In 10 per cent of the cases there is direct extension of infection from the primary focus to neighboring organs, such as the middle ear, mastoid, and lateral sinuses of the skull; in the remainder, metastases occur in various organs of the body. Abscesses of the muscles, osteomyelitis, and arthritis are most frequent. Indeed, abscesses may occur in many organs during the course of this type of sepsis."—Chester S. Keefer, *loc. cit.*

9. "Pneumococcic Bacteremia. — In addition to the cases of pneumococcic bacteremia in pneumonia, there are instances in which pneumococciare found in the circulating blood without a preceding pulmonary infection. In the vast majority of these cases the organisms invade the blood from the throat, middle ear, or mastoid process, and only rarely from such foci of infection as cholecystitis, infection of the biliary passages, or a pyelonephritis. In a certain small number, there is no obvious portal of entry." —Chester S. Keefer, *loc. cit.*

10. "When metastases occur, however, they are found most often in the subacu-

taneous tissues, in the meninges, in the endocardium, and less often in the joints. Repeatedly positive blood cultures due to the pneumococcus following pneumonia or serum treatment should always lead one to suspect an active, vegetative endocarditis or meningitis or both."—Chester S. Keefer, *loc. cit.*

11. "When pneumococcic bacteremia is present without a preceding infection of the lung, one usually finds that the portal of entry is in the mastoid process or middle ear, rarely in the biliary tract or the paranasal sinuses. One curious thing is the high frequency of pneumococcic bacteremia in patients with hepatic cirrhosis and in the nephrotic syndrome. Bacteremia occurring without signs of localizing infection, then, should always lead one to suspect some underlying disease of the liver."—Chester S. Keefer, *loc. cit.*

12. "Bacillus Coli Bacteremia. — The normal habitat of the colon bacillus is in the gastro-intestinal tract. Once the organisms leave this region and localize in such organs as the kidney or uterus, they frequently set up a suppurative lesion. The chief portals of entry are the urinary tract, the female genital tract, the intestinal tract, and the biliary tract, and the biliary system. In only about one-third of the cases is the invasion of the blood a spontaneous one, since in the remaining cases a rupture of the local defense mechanism, usually by operative manipulation, is a factor preceding, and possible initiating the blood stream invasion. Metastatic lesions are infrequent and occur in about one-fifth of the cases. They are seen especially in the cases of genital tract infection, and the lungs and kidneys are the two organs showing signs of metastatic infection. The fatality rate is about 30 to 35 per cent and of chief importance in prognosis is not the bacteremia itself but rather the extent, severity, and location of the primary focus."—Chester S. Keefer, *loc. cit.*

13. "Friedlander's Bacillus.—Bacteremia due to the Friedlander bacillus usually comes from a focus in the lungs, biliary tract, or kidney. Metastases and secondary waves of bacteremia have been seen following infections in the bones, joints, and other organs. Temporary waves of bacteremia follow the rupture of the local defense mechanism in the urinary or biliary tract. Much less commonly, spontaneous waves of bacteremia come from liver abscesses, pylephlebitis, and renal tract infections. The presence of these organisms in the blood always suggests liver abscesses, renal infections, or pulmonary disease."—Chester S. Keefer, *loc. cit.*

14. "Bacteremia in a patient with mastoiditis should immediately raise the question of a complicating lateral sinus thrombosis."—Chester S. Keefer, Calif. & West. Med. 53: 1940.

15. "Bacteremia following tonsillitis suggests thrombophlebitis of the tonsillar veins." —Chester S. Keefer, *loc. cit.*

16. "Pneumococcus bacteremia without pneumonia suggests (a) osteomyelitis, (b) paranasal sinus disease, (c) pneumococcus infection of the peritoneum or biliary passages, especially in patients with cirrhosis of the liver, or lipoid nephrosis and, (d) pneumococcic endocarditis."—Chester S. Keefer, *loc. cit.*

17. "Hemolytic streptococcal bacteremia without obvious local signs of infection, should suggest thrombophlebitis of the pelvic veins, the tonsillar veins, or the veins of the skull, rarely thrombophlebitis of the axillary or pulmonary veins." — Chester S. Keefer, *loc. cit.*

18. "In occasional cases of typhoid or paratyphoid bacteremia the primary focus is in the gall-bladder, spleen or kidney and not in the gastro-intestinal tract." — Chester S. Keefer, *loc. cit.*

19. "In examination of the abdomen careful inspection is probably, of all the methods employed, the most frequently neglected, and yet it is often the most profitable. It should be carried out from the side of the bed, from the head, from the foot, and, unless the case be an acute one, with the patient standing up."—Lord Horder — Medical Notes 1953.

20. "Tympanites, both gastric and intestinal, is sometimes caused by chronic alcholism. The condition may become so marked after an extra bout of drinking as to raise the question of intestinal obstruction." — Lord Horder, *loc. cit.*

21. "There is scarcely anything within the abdomen that may not share in a severe enteroptosis; even the abdominal aorta may be freely movable and considerably displaced."—Lord Horder, *loc. cit.*

22. "Congestion of the liver in dilation of the heart may be a more acute affair than is sometimes realized. It may lead to such rapid enlargement of the organ and may cause so much pain and tenderness, that the condition comes to simulate an acute inflammation. It may even lead to puncture or to an exploratory laparotomy, in the belief that the patient is suffering from hepatic abscess."—Lord Horder, *loc. cit.*

23. "Carcinoma of the colon with ulceration sometimes gives rise to marked symp-

toms of toxic absorption: fever, sweats, pains in the joints and fibrous tissues; and this state of things may precede abdominal symptoms or the discovery of an abdominal tumor."—Lord Horder, *loc. cit.*

24. "An occasional cause of persisting fever without physical signs, and without positive blood cultures, is a slowly developing abscess of the liver due to Staph. aureus. Although this condition may have been preceded by some form of furunculosis, the fact may be over-looked, either because the skin lesions have not been very conspicuous, or because there has been an interval between the complete healing of these lesions and the development of the hepatic focus."—Lord Horder, *loc. cit.*

25. "Because a patient suffering from ulceration of the stomach is elderly it is not un-common to argue that this fact favours malignancy. The argument is fallacious, because peptic ulcer is quite common in men over seventy years of age. Age, of itself, gives no help in differential diagnosis."—Lord Horder, *loc. cit.*

26. "In the differential diagnosis of simple form malignant ulcer of the stomach too little stress is often laid upon the significance of a frank haematemesis. In the presence of this complication simple ulcer becomes highly probable, for erosion of an artery rarely occurs in carcinoma, whereas it is common event in simple ulcer."—Lord Horder, *loc. cit.*

27. "Ascites arising insidiously in a woman in whom there are no other symptoms or signs (e.g. of heart, kidney or liver disease) is generally due to ovarian adenoma. The growth, being sometimes very soft in consistency, may not be felt by vaginal examination, and so may require laparotomy for its demonstration."—Lord Horder, *loc. cit.*

28. "The most frequent antecedent to suppurative pylephlebitis (portal pyaemia) in this country is a septic appendix. Desperate though the condition is, recovery does occasionally take place, the patient living long enough to admit coalescence of the multiple foci of suppuration and evacuation of the abscess so formed."—Lord Horder, *loc. cit.*

29. "Eosinophilia in disease of the liver is not peculiar to hydatid disease. It may occur in some other diseases of this organ, as in neoplasm, especially if the growth be a rapid one."—Lord Horder, *loc. cit.*

Border Health Association Will Hold Annual Meeting

The United States-Mexico Border Health Association will hold its 12th annual meeting April 6 through 9 in Albuquerque.

Officers of the Border Health Association are Richard F. Poston, sanitary engineer, San Francisco, president; Dr. Arturo Rico Gonzalez, Chihuahua, Chih., president-elect; Dr. Carlos Hernandez Aguirre, Ciudad Juarez, Chih., vice-president; J. Harold Tillman, sanitary engineer, El Paso, vice-president; and Dr. Sidney B. Clark, El Paso, secretary.

Board of trustees consists of Dr. Fred L. Soper, Washington; Dr. Ignacio Morones Prieto, Mexico, D.F.; Dr. Leonard A. Scheele, Washington; Dr. Manuel Pesqueira, Mexico, D. F.; Dr. Felipe Gonzalez Teran, Victoria, Tamaulipas; Dr. Salvador Molina Velez, Monterrey, Nuevo Leon; Dr. Ignacio Quiroz Leon, Saltillo, Coahuila; Dr. Arturo Rico Gonzalez, Chihuahua; Dr. Victor Ocampo Alonzo, Hermosillo, Sonora; Dr. Alfredo Martinez Manautou, Mexicali, Baja California; Dr. George W. Cox, Austin, Texas; Dr. Clarence G. Salsbury, Phoenix; Dr. Wilton L. Halverson, San Francisco; and Dr. James R. Scott, Santa Fe.

Dr. Oswalt Named President of District I Medical Group

Dr. Charles E. Oswalt, Jr., of Fort Stockton, Texas, was elected president of District 1 of the Texas Medical Association in Pecos, Texas, February 12 at the annual meeting attended by 47 West Texas physicians, 23 of whom were from the El Paso County Medical Society.

Other officers elected were Dr. H. M. Gibson of El Paso, vice-president, and Dr. H. D. Garrett of El Paso, who was re-elected secretary-treasurer.

Scientific papers were presented by Dr. Robert F. Thompson of El Paso, "Congenital Kidney Anomalies as a Cause of Pain and Diseases;" Dr. Newton F. Walker, El Paso, "Some Common Eye Conditions That Should be Recognized in General Practice;" Dr. Ross W. Rissler, El Paso, "The Newer Hypertensive Agents;" Dr. Celso C. Stapp, El Paso, "Control of Pain in Childbirth;" Dr. Leigh E. Wilcox, El Paso, "The Surgical Treatment of Thyroid Disease;" Dr. Maynard S. Hart, El Paso, "Early Diagnosis of Tumors of the Lung;" and Dr. C. A. Robinson, Kermit, "Early Diagnosis and Treatment of Congenital Dislocation of Hip". Dr. George Turner of El Paso, Texas Medical Association president, also spoke.

The 1955 annual meeting will be held in Pecos.

HYPOTHYROIDISM—OFTEN FORGOTTEN*

By Jack A. Bernard, M. D., El Paso

Mild hypothyroidism often may escape recognition unless one is alert to it. Undoubtedly many persons with slight degree of thyroid failure are daily carrying on their work and pass as normal, at the same time not realizing that better health might be obtained. Twenty-seven cases are being presented, in which cases it was thought that the thyroid function was a factor in the evaluation of the complaints that were presented.

It is not intended to claim that in all cases of lowered vitality a lessened thyroid secretion is the only cause. Other conditions to be considered are fatigue from carrying on physical or mental overload, particularly the latter; infectious diseases; foci of infections, a poorly balanced, or inadequate diet, with vitamin deficiencies, and others. All of these have been thoroughly investigated, searched for and eliminated.

The hint to suggest the condition of mild hypothyroidism is in the patient's history. It is indefinite. It is not clear as to onset. He is sufficiently disturbed to seek the advice of a physician, and usually has sought the advice of many physicians. He has to drive himself to his tasks. It is an effort for him to get started and keep going.

Sooner or later joint pains may develop, particularly in the hips, shoulders, or knees. He may complain of being "tired out", "short of breath", "dizzy." In the reported cases, complaints were listed as follows:

SYMPTOMS	CASES
Joint Pains	9
"Tired out"	5
"Shortness of breath"	4
Dizziness	4
Menstrual abnormalities	5
Headache	3
Nervousness	3
"Can't sleep"	3
Angina	2
Others (voice changes, deafness)	1 each

Blumgart, in following the development of hypothyroidism, after total thyroidectomy in the treatment of chronic heart disease, listed as the signs of hypothyroidism: "Dryness of the skin, absence of sweating, puffiness, irritability, fatigue, drowsiness, tinnitus, numbness of fingers." He also noted that "untoward-symptoms were immediately manifest of hypothyroidism, almost without exception, when serum cholesterol increased above 300 mg. per cent."

The laboratory findings in the present series are best summarized by Table I.

TABLE I

Case	Age	Sex	BMR	Chol.	Anemia	Ekg.
F.B.W.	51	F.	—27	226	No	Abnormal
W.L.M.	65	F.	—26	324	No	Abnormal
R.M.B.	31	F.	—33	570	No	Abnormal
H.H.	59	M.	—33	522	No	Infarct
J.J.	63	F.	—28	226	No	Normal
J.S.M.	42	F.	—31	290	Yes	Normal
V.J.	46	F.	—26	334	No	Not Done
F.H.	42	F.	—22	231	No	Normal
F.B.	33	F.	—22	161	Yes	Not Done
E.S.	27	F.	—16	238	No	Not Done
E.T.	56	F.	—14	314	No	Abnormal
C.R.	63	F.	—28	369	No	Infarct
G.L.	35	F.	—23	157	No	Normal
G.L.	42	M.	—14½	334	No	Normal
J.K.	64	M.	—39	314	No	Normal
J.S.S.	22	F.	—15	159	No	Not Done
W.H.	43	F.	—22	260	No	Not Done
P.E.T.	39	F.	—37	Not Done	Not Done	Not Done
J.S.	45	F.	—25	320	Slight	Abnormal
M.T.	44	F.	—18	260	Not Done	Not Done
P.J.	38	F.	—29	290	No	Not Done
J.C.	57	M.	—27	285	No	Abnormal
R.H.	15	M.	—17	301	No	Not Done
C.H.S.	45	M.	—14	Not Done	No	Not Done
B.G.	12½	F.	—30	213	No	Not Done
A.M.R.	59	M.	—13	636	No	Not Done
W.H.S.	29	F.	—32	235	Not Done	Not Done

The following case histories are presented to illustrate some of the above features:

CASE H. H.

Case H. H. who was seen Jan. 8, 1951, with the history of "looking bad," and who came in, stating, "everyone says I look bad." His wife stated that he had been quite sleepy, lethargic, irritable, "childish", and that he had refrained from taking responsibility, and seemed to have some impairment of memory.

Physical examination revealed a pale, sallow, expressionless, puffy faced, male, with suborbital edema, sagging jowls, thinning of the eyebrows laterally, dry wrinkled sallow skin, and a husky voice. Nose and throat consultation revealed no abnormalities of the nasal pharynx or larynx. Blood pressure 110/90. Heart and lungs were normal. Abdomen: Normal, no liver palpable. Extremities: No edema.

Laboratory findings: Revealed a BMR of minus 33 per cent. Hemogram was normal, with RBC 4.5, HB: 16 gms, WBC: 6,800. Blood cholesterol 522 mg. per cent. Total serum proteins — 5.83, with albumin 3.12, globulin 2.71.

Electrocardiogram showed low P wave,

* Presented at annual meeting of District One Medical Association of Texas, Feb. 13, 1953 at El Paso, Texas.

with very low R waves throughout chest leads, and flat T wave. (Patient had had an acute anterior myocardial infarction May 9, 1950.)

Treatment was instituted with thyroid grains one-fourth daily, and when seen nineteen days later, he looked better and was less hoarse, and had lost 3 pounds in weight. BMR was minus 24 per cent.

On September 7, 1951, about eight months after he started his thyroid therapy, the patient's weight was down to 131¼ and the suborbital edema had subsided. BMR was minus 21 per cent cholesterol 440 mg. per cent, and EKG was then normal. (Voltage was higher, and T waves were higher).

On January 27, 1953, patient appeared well, felt well. His edema, sallow complexion, and voice changes had disappeared. BMR was minus 30 per cent. Cholesterol 209 mg. per cent. Electrocardiogram showed a normal tracing. Thyroid was increased to one-half gr. daily.

This case is presented to illustrate a case of hypothyroidism, in a patient with a previous myocardial infarction, whose friends noted his poor health more than the patient himself. As regards diagnosis, the differential diagnosis when this patient was first seen included heart failure, (in view of his past history of a coronary occlusion) hypoproteinemia, and hypothyroidism. Patient was obviously a case of hypothyroidism, and this needs no further comment. It should be noted that thyroid was administered cautiously because of the well recognized danger of precipitating angina in such cases by the injudicious use of large doses of thyroid.

CASE W. L. M.

A 65 year old female who was seen Oct. 15, 1952, with the history of awakening at midnight three days before with a "hurting" across upper chest, which radiated up into the neck and into the arms, and which lasted about an hour.

Patient came in because another physician had checked her two years ago for a syncopal attack, and had frightened her when he told her she had "hardening of the arteries".

Review of systems revealed other symptoms; such as, ringing of the ears, constipation, "nervous stomach".

Physical examination revealed a pale, sallow, female, who appeared older than her stated age. Hair was dry; skin was inelastic, with a yellowish tint. Heart and lungs examination was normal. Extremities showed absent posterior tibial pulsations on the left, with diminution of the other vessels.

Electrocardiogram showed myocardial damage with flat T-waves, in the unipolar and the limb leads.

Laboratory findings showed normal hemogram with RBC 5.35, HB: 15.5, WBC: 5,400, Blood smear normal. Sed Rate was 19 mm. per hr. BMR — Minus 26 per cent, Blood cholesterol — 324 mg. per cent.

Patient was started on thyroid grains one-fourth daily, and returned to the office on October 30, 1952 (two weeks later) stating that "she felt better than she had felt in ten years". Thyroid was increased to one-half grain daily, and on December 15, 1952 (6 weeks later) patient stated, that she was "feeling better and had had no more spells". (She had had no chest pain). She stated that she required less laxative than before. Her husband noted her skin was better, stating that her eyes were brighter, and her family thought that her nervousness was improved. Physically, the patient looked better. Her color was improved, and her hair had more luster. She weighed 156¼ pounds, a loss of three pounds in weight.

Electrocardiogram showed improvement over tracing of October 1952, with slightly higher T waves in I, II, V_4, V_5, V_6, and AVL. A BMR was minus 8 per cent, as compared to minus 26 before, and blood cholesterol had dropped to 104 mg. per cent.

This case is presented to show a typical case of hypothyroidism in a patient with arteriosclerotic heart disease with angina pectoris and a myocardial infarction. Again, caution in the use of thyroid in such patients is emphasized.

CASE J. S. M.

A 42 year old female, who was seen June 27, 1952, for a check-up because of pain in her right hip, and right leg, and particularly because "she was always worried and exhausted, and felt "like I don't want to live any more".

Review of systems revealed that she "hurt all over", and particularly complained of occipital headaches. She complained of "sinusitis" with postnasal drip, of shortness of breath, heart pounding when she was nervous, or mad. Ankles swelled easily. She complained of stomach trouble, easy nausea, dizziness. She was bothered with constipation. She had nocturia two to three times nightly, and urgency when excited. Her joints hurt all the time, particularly left elbow, left shoulder and legs. She gave a past history of a pelvic discharge, of nonspecific nature, treated by her Gynecologist.

Physical examination revealed an obese, slightly sallow, puffy female, weighing 138½ pounds. Skin was sallow and pale. Exami-

nation of the heart and lungs was normal. Extremities showed no edema.

Electrocardiogram showed normal tracing.

Laboratory findings revealed a Red count of 3.48, Hemoglobin 10.2 White count 6,400 with normal blood smear: Polys 57, Lymphs 40, Monos 2, Eosinophils 1. Urinalysis showed negative albumin, negative sugar, and negative microscopic.

B. M. R. was minus 31 per cent. Fasting blood cholesterol 290 mg. per cent.

Patient was started on thyroid, grains one-half daily, and was seen on August 11, 1952 (14 days later) and stated that she felt "super". Thyroid was increased to 1 grain daily, and on October 29, 1952 (about one month) after the start of thyroid, she stated that she felt fine, and patient looked grand. At this time her hemogram was normal, RBC = 4.7, HB: 12.55, WBC = 8,250.

On December 2, 1952 the patient weighed 136 3/4 lbs. a loss of two pounds, and stated that she was so much better, was always hungry. She had had no more back pains, or hip pains.

This patient is presented to illustrate the numerous complaints with which patients with hypothyroidism may present themselves, and particularly, many of them will present themselves with complaints of joint pains, as this patient.

Also, this patient presented an anemia, which it is felt was secondary to her hypothyroidism, as other causes were searched for and eliminated: There was no history of any bleeding episodes, and there was no evidence of any bleeding diathesis, or blood destruction; and patient was given no hematemics; only thyroid was prescribed, and her anemia responded well to thyroid therapy alone.

In conclusion, we wish to point out that: 1. The diagnosis of mild hypothyroidism may escape recognition unless one is alert to it, as various symptoms may present themselves, particularly various aches and joint pains, and patient himself may not be aware of his lowered well being. 2. That the recognition of thyroid disease is primarily the function of the clinician, not of the laboratory technician, and 3. No single test can completely replace clinical judgment either in the recognition of thyroid dysfunction or concerning the progress of the disease. 4. Finally, caution in the use of thyroid in patients with arteriosclerotic heart disease with angina pectoris is emphasized.

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HALLUX VALGUS

Hallux Valgus

Lancet 1:331, 1953

Several investigators have recently attempted to elucidate the etiology of hallux valgus and to assess the value of various corrective operative procedures. Some observers contend that the condition is brought on by wearing tight, improperly fitted shoes while others believe that widening of the first intermetatarsal angle is primarily responsible. The author of this article states that there is "commonly no apparent cause whatever for hallux valgus." Corrective operations are notoriously unsuccessful and are attended by a high proportion of failures, either from recurrent deformity and pain or from interference with the function of the foot.

Clinical Clippings, May, 1953.

PRURITUS

An Effective Method For The Treatment Of Pruritus With The Oral Use Of Procaine Hydrochloride-Ascorbic Acid Combination

Parish, F. A., Ann. Allergy 11:85, 1953

Oral administration of tablets, each containing 250 mg. procaine hydrochloride and 150 mg. ascorbic acid* brought about prompt relief of pruritus in the majority of 31 patients. Conditions for which these patients were treated included atopic dermatitis, urticaria, contact dermatitis, poison ivy, seborrhea, pruritus vulvae, pruritus ani and scabies. There were no side effects nor did any of the patients mention the occurrence of untoward reactions.

**Supplied by Dr. Josselyn, Abbott Laboratories.*

Clinical Clippings, May, 1953.

CLINICAL AND LABORATORY ASPECTS OF HYPERSPLENISM

By Ashton B. Taylor, M. D., and James D. Barger, M. D., Phoenix

Diseases of the hematopoietic system in which the spleen is the major factor are not common. However, they present a fascinating and oftentimes puzzling problem in laboratory diagnosis which requires close cooperation between the clinician and the pathologist to establish the correct diagnosis and to evaluate the proper therapy. Such a goal demands an orderly and rational approach so as to prevent the accumulation of unrelated and confusing data which does little to clarify the problem at hand.

CLINICAL FEATURES

The term hypersplenism is fairly new in medical literature. The term is a good one and infers a function of the spleen which serves to increase the breakdown of one or more of the formed elements of the blood. The mechanism by which this occurs is not established but is rather hotly contested by the hematologists. In essence, two schools of thought exist regarding the process which operates in hypersplenism. The one which seems to have the most widespread favor at the present time holds that there is a basic plasma defect which increases the susceptibility of the blood elements to destruction by the spleen. The other school holds that the spleen is capable of a hormonal function by which means the blood elements may be selectively or totally depressed.

Regardless of the mechanism which operates we recognize that specific disease entities do result from hypersplenism and can be identified by a deficiency of platelets, red cells, granulocytes or by a deficiency of all of these elements together. We also recognize that these disease entities may be classified as primary if they are congenital or hereditary and secondary if they occur as a complication of other disease.

Primary Hypersplenism has four separate recognizable forms.

1. Idiopathic Thrombocytopenic Purpura in which the blood platelets are selectively depressed.

2. Congenital hemolytic anemia in which the circulating erythrocyte is the target cell.

3. Splenic neutropenia in which the neutrophilic granulocytes are selectively depressed.

4. Splenic pancytopenia in which all of the above mentioned blood elements are depressed.

Splenectomy in this group of disorders will effect a cure.

Secondary hypersplenism refers to those situations in which the clinical picture is identical to those mentioned above but which occurs as a complication of a chronic disease. Thus, for example, the platelets, erythrocytes or granulocytes may be depressed secondary to some chronic disorder which is itself responsible for the hypersplenic state. The commonest causes for secondary hypersplenism include the leukemias, so called Banti's dis ease, Hodgkin's disease, lymphosarcoma, sarcoidosis and certain infectious processes such as malaria or typhoid. In this group of secondary hyperesplenism it is common to also include acquired hemolytic anemia and Felty's syndrome. For this group of cases splenctomy may prolong life by stimulating a remission of the cytopenia but it will not alter the eventual outcome of the disease.

The one absolute prerequisite for splenectomy is correct diagnosis. Studies of the peripheral blood alone are inadequate. It is essential that the bone marrow be examined by a competent hematologist or pathologist. In hypersplenism there must always be a hyperplasia in the marrow for the specific cell or cells which are depressed in the peripheral blood. It is imperative that hypersplenism be distinguished from both primary and secondary marrow suppression. In these days of widespread use of potent therapeutic agents, it is far more common to find toxic suppression of the bone marrow than hypersplenism. Confusion of these two processes is all too easy since the peripheral blood picture may be identical. Only examination of the bone marrow will reveal the depression of marrow activity which is characteristic of the aplastic or hypoplastic process. These matters are discussed more completely under the section on laboratory aspects.

The role of the steroid hormones in controlling the manifestations of hypersplenism is still not evaluated. There is no question that ACTH and cortisone are capable of inducing a remission in both primary and secondary hypersplenism. In secondary hypersplenism these agents may well serve as a total form of treatment but in hypersplen-

ism of the primary variety they do not offer the total cure of splenectomy. However, they may well serve as excellent preoperative preparation and in the control of postoperative complications. These agents are also being employed as diagnostic tools prior to surgery.

LABORATORY DIAGNOSIS

In this discussion of laboratory procedures, the reader is referred to review articles for a detailed bibliography. As in any disease in which the hematopoietic system is involved, the most necessary procedure is the complete blood count. This should include a red blood count or hematocrit. The hematocrit has the advantage of better reproducibility of the results, and is especially useful in following the results of therapy of anemias. The determination of the hemoglobin concentration should be done by an adequate method. Although it is a commonly used procedure there are many difficulties associated with it; the reader is referred to the recent review of problems in clinical hemoglobinometry by Sunderman, et al,[1] for a discussion of methods. The enumeration of the leukocytes and a differential count supply necessary information. In addition, there should be a platelet count. This is a rather difficult procedure for which a number of methods are available, all of which have sources of error. However, in a laboratory where platelet counts are done with some frequency, it is possible to establish a normal range and to judge fluctuations of the platelet count from the norm. It is important to remember that not only the number of the platelets in a thrombopenia, but also the duration of the condition is responsible for the bleeding seen in these patients. In other words, an acute thrombopenia in itself will not induce capillary bleeding, but chronic thrombopenia will show capillary bleeding due to some factor in addition to the thrombopenia. Enumeration of the reticulocytes in the peripheral blood is very useful. For this examination, it is recommended that the staining of the reticulocytes be done by the use of the dye, methylene blue N.[2] This is an important part of the examination, since it gives an indication of the erythropoietic activity of the bone marrow.

In any disease of the hematopoietic system, a bone marrow examination is necessary to properly evaluate the condition. The methods of bone marrow examination vary from laboratory to laboratory. An adequate review of methods was recently made by Berman.[3] The procedure outlined will give adequate material for a critical examination.

The examination of the bone marrow is especially important in the type of disease under discussion. For example, in any of the hemolytic anemias, there is a marked increase in erythropoiesis of the normoblastic type. This serves to differentiate this disease from pernicious anemia and other anemias. In thrombocytopenia, the enumeration of the megakaryocytes may be of some value in prognosticating the results of splenectomy.[4] When the presenting sign in the peripheral blood is a leukopenia, bone marrow examination is a necessity. Leukopenia may be a manifestation of so-called "aleukemic" leukemia, granulocytopenia, or pancytopenia due to a drug sensitivity or to unknown causes, and the proper diagnosis can be made only by bone marrow examination. The most important diseases in which splenectomy may be of some value are the hemolytic anemias and thrombocytopenia. Further laboratory tests are necessary for evaluation of these conditions. The best known is the measurement of osmotic fragility of erythrocytes in hypotonic saline solution. Congenital hemolytic anemia is characterized by erythrocytes of abnormal shape (spherocytes), which have an increased osmotic fragility. Other types of hemolytic anemia with numerous reticulocytes present in the peripheral blood show a decrease in osmotic fragility, since the reticulocytes are more resistant to the hypotonic solutions of saline than the mature erythrocytes. In thalassemia (Mediterranean anemia), there is a very marked decrease in the erythrocyte fragility which, in combination with the morphology of the peripheral blood, is diagnostic. It is important in hemolytic anemias to attempt the demonstration of abnormal forms of erythrocytes. The morphology of the erythrocyte in the peripheral blood will make the diagnosis of thalassemia or sickle cell anemia. In addition, preparations are made for the demonstration of the sickling phenomena. It is also possible to demonstrate abnormal hemoglobin molecules by alkali denaturation and electrophoresis. However, these particular procedures are, at the present time, not within the scope of the usual clinical laboratory. With the advent of filter paper electrophoresis these demonstrations may become more useful. Recently, much attention has been directed to the demonstration of autoantibodies in acquired hemolytic anemia. These antibodies have been known to exist for some time, but only recently have they been thoroughly investigated.[5] The antibodies are usually first demonstrated on the erythrocytes of the patient by the 'direct' Coombs technique. It is also well to investigate the patient's serum for antibodies by the 'indirect' Coombs technique using a battery of cells as has been suggested by Da-

vidsohn. The various test cells consist of(1) the patient's erythrocytes,(2) erythrocytes of the homologous blood group and(3) erythrocytes of Group "C". These antibodies are usually nonspecific and agglutinate any one or all of the test cells. Difficulties which may arise in attempts to cross-match the blood of these patients in preparation for blood transfusion, also may be due to these antibodies. Probably, antibodies against the leukocytes and the platelets are also present in many instances. Harrington, et al,(6) have demonstrated anti-platelet antibodies in cases of thrombocytopenia. Patients with hemolytic anemia should be supported by transfusions (previous to splenectomy) and an attempt made to restore the erythrocytes to a near normal level. For this purpose, we prefer the use of red cell mass, giving erythrocytes in a minimal amount of plasma. In transfusion therapy, one often encounters difficulties obtaining a compatible cross-match of the donor's and recipient's blood. This is due to the presence of autoantibodies, and if the correct blood type of the patient is known or can be determined, the patient is transfused with homologous type blood regardless of the incompatible cross-match. This is not without danger and the patient should be watched very carefully for a possible hemolytic transfusion reaction. Transfusion reactions are unpredicable in these patients. In one of our cases, before splenectomy, the patient was transfused four times with no untoward results. A month later, she entered the hospital again and was transfused once successfully. The second time, two days later, she had a severe hemolytic transfusion reaction. After splenectomy, there was one successful transfusion. A second transfusion was again followed by a very severe hemolytic transfusion reaction. No further attempts at transfusion were made and the patient has recovered quite satisfactorily.

As with many other diseases, ACTH and cortisone are useful in the treatment of hemolytic anemias and thrombocytopenia. The exact mechanism of its function in acquired hemolytic anemia is not known, but it probably interferes in some manner with the antigen-antibody reaction and reduces the hemolytic process. Some patients with acquired hemolytic anemia having autoantibodies show a decreased rate of hemolysis following treatment with ACTH or cortisone. With cessation of the treatment, there is a relapse and renewal of the treatment again causes a remission. In thrombocytopenia, the action of the ACTH may be to strengthen the capillary walls and thus prevent capillary bleeding. It does not appear to have any direct effect to increase the number of platelets.

SUMMARY

The role of hypersplenism in diseases of the hematopoietic system has been discussed and a classification of hypersplenism presented. The importance of differentiating primary and secondary hypersplenic states is stressed. The laboratory aspects involved in establishing a correct diagnosis are reviewed.

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STREPTOKINASE — STREPTODORNASE

Streptokinase And Streptodornase In The Treatment Of Surgical Infections

Miller, J. M., et al., Lancet 1:220, 1953

Lubafax, a water-soluble base, is a useful vehicle for streptokinase and streptodornase. The preparation used by these investigators consisted of streptokinase, 300,000 units, streptodornase, 75,000 units, and crystalline aureomycin, 0.05 Gm. dissolved in physiological saline solution and added to 30 cc. Lubafax. The suspension is said to retain its potency for about one week when stored in a refrigerator.

N. Y. U.

Clinical Clippings, May, 1953.

EPILEPSY

Newer Drugs In The Therapy Of Epilepsy

Perlstein, M. A. & Mizell, I., Bull. Northwestern U. Med. School 27:59, 1953

In discussing antiepileptic drugs the authors caution against concurrent administration of Mesantoin and Tridione or Paradione. "The toxicity of both of these classes of drugs is much more enhanced when they are given together than when they are given separately. Mesantoin, therefore, should never be given in combination with the two latter drugs."

REPETATUR: Based on present biological evidence, the life span for humans will probably never exceed 100 to 125 years regardless of advances in medical knowledge.—Wakedin.

Clinical Clippings, May, 1953.

The Duration of the Q-U . . .

(Continued From Page 109)

the Q-oT interval to be more prolonged than any other component of the Q-U interval; a prolongation of Q-oT beyond 65 per cent seems accordingly to be the most certain sign of hypocalcemia. On the other hand, this study shows that in pure hypopotassemia the Q-T interval and its components is not porlonged; in all published cases in which Q-T seemed to be prolonged, a part of the U wave was included into the Q-T interval or there were present other factors which tend to prolong Q-T (such as decrease in the ionized calcium, acidosis, etc.)

ERYTHROMYCIN

Resistance Of Bacteria To Erythromycin

Haight, T. H. & Finland, M., Proc. Soc. Exper. Biol. & Med. 81:183, 1952

Resistance to erythromycin can be induced *in vitro*. Staphylococcal strains of markedly increased resistance to erythromycin were obtained from blood cultures of 2 patients with endocarditis following 7 to 10 days treatment with this antibiotic.

REPETATUR: During a hospital stay many a respectable citizen has been deranged temporarily by sedation because the intern thought the patient needed a good night's rest. — Salter. Clinical Clippings, February, 1953.

"In acute constipation, the cathartic of choice is the . . . one which will produce a prompt and complete evacuation *without excessive purgation*." (Cornell Conference on Therapy, Vol. III, p. 279)

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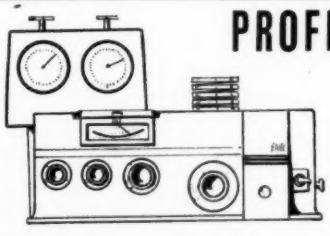

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